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NATIONAL HOSPITAL
PROSPECTIVE PAYMENT EVALUATION

CASE STUDY SITE REPORT
SOUTHWESTERN MONTANA

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TABLE OF CONTENTS

		PAGE
1.0	**OVERVIEW OF SOUTHWESTERN MONTANA**	1
2.0	**SCOPE OF INTERVIEWS**	2
3.0	**HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS**	5
	3.1 Competitive Environment	5
	3.1.1 Price Competition	6
	3.1.2 Non-price Competition	6
	3.2 Management Cost Control	10
	3.3 Hospital Performance under PPS	12
	3.4 Complaints about PPS	14
4.0	**PPS AND ALTERNATIVE HEALTH PLANS**	16
5.0	**MEDICAL PRACTICE PATTERNS UNDER PPS**	17
	5.1 Background	17
	5.2 Hospital Controls on Practice Patterns	18
	5.3 Perceived Problems with Respect to Patterns and PPS	21
6.0	**THE POST-HOSPITAL HEALTHCARE INDUSTRY UNDER PPS**	23
	6.1 Hospital Discharge Planning	23
	6.2 Home Health Agencies	23
	6.3 Nursing Home Facilities	24
7.0	**PROGRAM OPERATIONS**	26
	7.1 Peer Review Organization	26
	7.1.1 SuperPRO Ratings	26
	7.1.2 Quality Assurance and Record Reviews	26
	7.1.3 Denials and Sanctions	27
	7.1.4 Specific Site Issues	27
	7.2 Fiscal Intermediary	28
	7.2.1 Claims Processing	28
	7.2.2 Utilization and Medical Review	29
	7.2.3 Relations with Hospitals	29
	7.2.4 Federal Policies and the FI	30

PREFACE

This is one of ten site reports of case studies conducted between September and December, 1986, by staff members of Abt Associates, Inc. and Health Economics Research, Inc. under Contract No. 500-85-0015 to the Health Care Financing Administration (HCFA). The views expressed are our own and no endorsement by HCFA or the Department of Health and Human Services is intended or should be inferred. Each report is a summary of the facts and subjective comments from all participants at one of the ten sites.

This report characterizes the structures of parts of the health care industry (e.g., hospitals, nursing homes, home health agencies) in this site as they were perceived by members of the study team. Individual respondents and institutions are not mentioned by name, nor are they meant to be identifiable. We are interested in generalizing about the responses of the industry to the Medicare prospective payment system, not in pointing out any one type of response. We would like to raise the appropriate policy issues objectively and from all points of view. These issues can then be addressed in the statistical analyses of data on beneficiaries and providers, which in turn will be synthesized by HCFA staff into the Congressionally-mandated report about the impacts of the prospective payment system.

The ten site reports will not make up the report to Congress. The ten sites are not a scientifically representative sample of the nation's health care providers. Therefore, they are only illustrative of what is happening across the country. As such, they have already proven to be invaluable to the study staffs. The information and subjective opinions of the 500-600 respondents will be incorporated in the analyses of secondary data in five topic areas: hospital competition, alternative health plans, medical practice patterns, post-hospital care, and program operations. They are being used in developing hypotheses, exploring unexpected results and raising policy concerns.

We once again thank those many respondents who so generously gave us their time for the discussions that provided these insights. Special thanks are also due to the support staffs of Health Economics Research and Abt Associates for arranging the site visits and producing the reports, and to the secretaries of participating executives who coordinated the interviewing schedules in the field.

1.0 OVERVIEW OF SOUTHWESTERN MONTANA

The southwestern region of Montana is a large, high plains and mountainous region, sparsely populated with a high quality of life but a depressed economy (due to depressed mining and cattle ranching industries). The health care industry in this eight-county area consists of seven hospitals, eleven nursing homes, and 161 physicians serving a population of about 125,000 spread over 18,802 square miles. (The population density of 6.6 persons per square mile is about one tenth of the U.S. average, or comparable to the national average in 1800.) The population is somewhat more elderly than the U.S. average (12.5% are 65 or older), with a hearty rural self-help attitude about health care and a disproportionate amount of chronic lung disease from the long dominance of mining in the local economy.

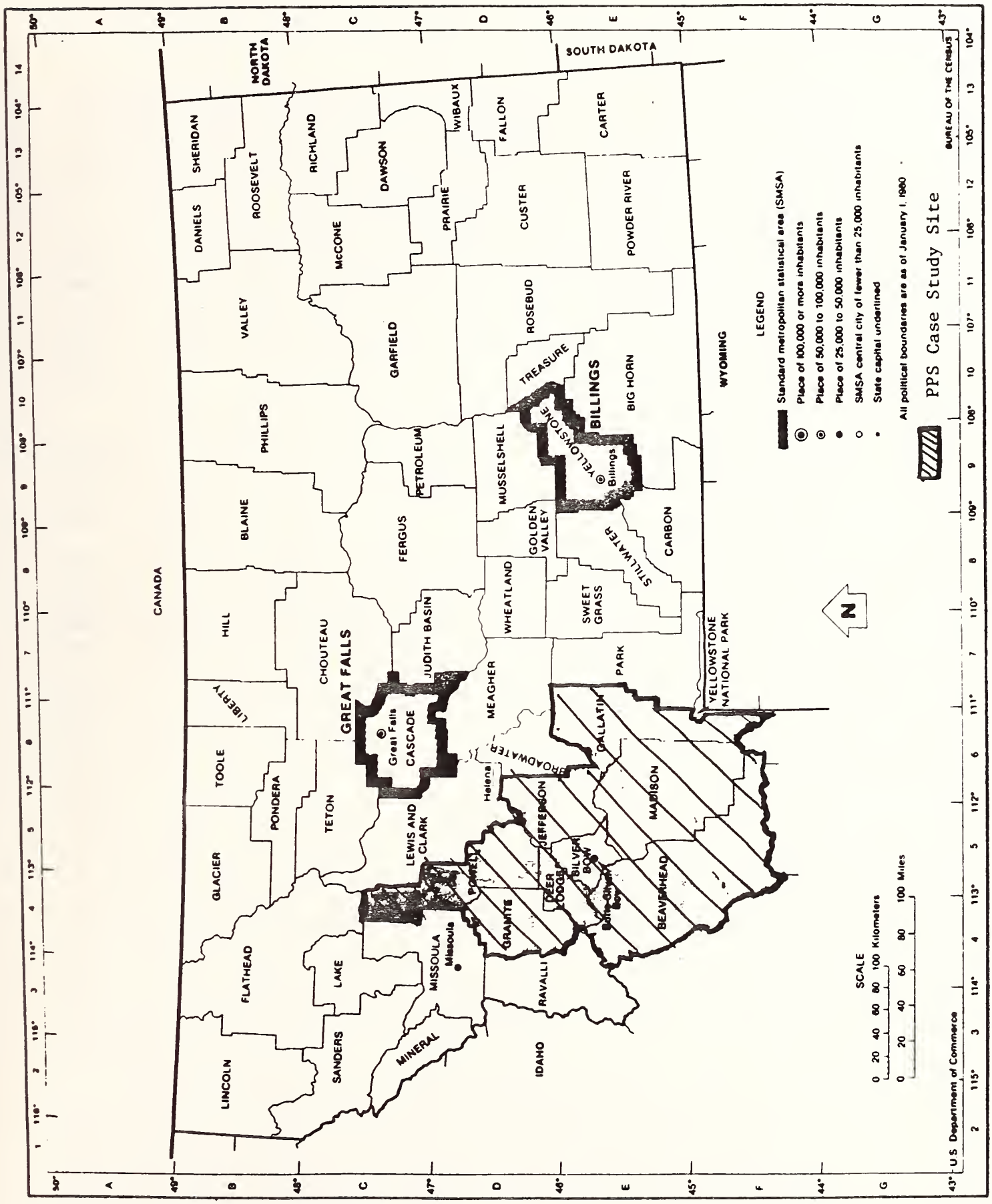
The hospitals in the region are very dispersed. As the accompanying map indicates, population centers within the area are sufficiently dispersed (25-85 miles) to allow six hospitals to be candidates for SCH status (though only 4 are currently designated). One larger hospital is also designated as a rural referral center. The others range in size from 11 to 74 beds. Occupancy is uniformally very low, ranging up to 50%. Several hospitals have an average daily census of less than 5 and only two admitting physicians. All hospitals receive some income from counties.

Hospitals must transfer virtually all cardiac surgery and highly specialized care cases to either Salt Lake City or Spokane. Some less specialized care is provided by hospitals in Billings (to the East) and Missoula (to the North). The latter city of 34,000 has three very underutilized hospital facilities and underemployed MDs, and has reportedly spawned a number of aggressive attempts to attract patients by offering convenient (instantaneous) appointment scheduling for outpatient services (notably ophthalmology).

Physician distribution in the region is not uniform. Butte and the remote southern areas have continuing needs for more physicians; the Bozeman area is better endowed. In the very remote sites (Sheridan, Dillon) it is customary for services like anesthesia, orthopedics, and ophthalmology to be supplied on a part-time basis.

Hospitals may choose to participate in an annual voluntary rate review process, which affords full charge reimbursement by Blue Cross. If hospitals fail to follow guidelines or choose not to participate, Blue Cross earns a five percent discount. Most, but not all, hospitals participate. Medicaid pays allowed costs, but has a tough mandatory preadmission certification program for all non-urgent admissions.

Hospitals throughout the region have continued to struggle with inpatient volume declines, which have been exacerbated by PRO pressures and some reductions in lengths of stay. The PPS blended rates have favored these hospitals, and have served as a timely financial influence, allowing most hospitals to maintain a small surplus from operations. The dispersed, isolated nature of the industry has not encouraged development of competitive behaviors, though hospitals are attempting to stem leakages of specialty care from their market areas through physician



DETAILED POPULATION CHARACTERISTICS

Source: Bureau of the Census, 1980 Census of Population (1981)

recruitment and diversification into subacute care services. Competition is evident between hospitals and local physicians, and on the perimeters of hospital market areas. Hospitals are very preoccupied with a basic survival strategy, independent from PPS, of maintaining (or reestablishing) an image of a "real acute care hospital" in the eyes of their community, in spite of their small size and modest service mix.

Hospitals' strategy in response to PPS has generally taken the form of cost control and revenue diversification (within the local area) rather than the types of strategic responses like practice pattern management or rivalrous competition for admitting physicians often seen in other areas. Most cost control has come in the form of large cutbacks in staff, including nursing, and slower rates of salary increase. All but one hospital has recruited a new CEO, which in several instances has been the first time experienced professional hospital managers have been in charge.

Hospitals are not aggressively pursuing continued stay review, physician profiling, administrative jaw boning, or skimming and dumping strategies. Some, but not all, hospitals appear to have physician profile information but do not appear to be using that information to control physicians. There certainly is no evidence that physician sanctions have been used.

Yet, length of stay and admissions have fallen, and some elderly physicians retired early. These events appear to be the result of a combination of apprehensive anticipation of the onset of PPS and documentation hassles from the PRO and Medicaid. These forces appear to have changed physician behavior (and retirement patterns) without implementation of invasive utilization control systems by hospitals.

The capacity of the post-hospital care industry seems adequate in general but with problems of access to home care in more isolated locations. Thus nursing home placements are not generally difficult to make, though home care capacity in the more rural parts of the region is often taxed, as most of the skilled care in these places is provided by one agency. Hospitals are entering this subacute market by providing services and converting beds. Community support programs for the elderly, particularly in mental health, are not readily available in most of the region. Most hospitals have swing beds which are seldom used -- in some cases the state pressured hospitals to designate more such beds than were initially requested by the hospitals. As an indicator of the concern of nursing home operators about excess capacity, the state legislature recently passed a law prohibiting hospitals from providing <u>any</u> convalescent (level II or lower) care using swing or acute beds; hospitals here <u>must</u> discharge such patients regardless of payor status if there are any unoccupied nursing home beds in a 100-mile radius. The Montana PRO supported this policy, noting that it would not certify unnecessary acute care when a nursing home bed within a reasonable distance was available.

PRO and FI activities are being conducted without many of the denial-related problems often heard in other regions. Denial rates are quite low for all types of services, and hospital providers are more constrained by Medicaid's admitting criteria program than the PRO's. PRO and FI activities are under substantial budget pressures, causing more off-site reviews, and payment lags. It is not clear that the scale of either administrative party is adequate to achieve suitable economies in review and payment activities.

2.0 SCOPE OF INTERVIEWS

There are seven hospitals in southwestern Montana. All are rural short-term acute-care hospitals. Five of these hospitals participated in the site case study: Four hospitals are fairly small, each with 100 beds or less. One has over 100 beds.

Thirty-eight people were interviewed but five did double duty by answering as both utilization reviewers and discharge planners. Table 1 presents the number of interviews by topic area and the positions of the respondents. Ten interviews focused on hospital competition and related topics; 10 were concerned with the utilization of resources and patient management in the hospital; 9 were conducted in the post-hospital health care industry; and two were with those involved in the operation of the state programs. There were no interviews with any representatives of alternative health plans.

To gain insights into the competitive environment of western North Carolina hospitals, five chief executive officers were interviewed about their strategies and the relative positions of their hospitals under PPS and in the area's health care market. Information relating to price competition and financial standing was obtained in interviews with five chief financial officers or hospital controllers.

In the area of utilization of hospital resources and patient management, the site team spoke with five utilization reviewers, one DRG coordinator and four physicians. For the aftercare industry, team members interviewed five hospital discharge planners (who also did utilization review), administrators of two nursing homes and two home health agencies. Interviews concerning program operations were conducted with three representatives of the PRO and six of the fiscal intermediary.

TABLE 1

SOUTHWESTERN MONTANA SITE VISIT INTERVIEWS BY TOPIC AREA

	Hospital Competition	Utilization and Patient Management	Aftercare Industry	Program Operations
CEOs	5			
CFOs/Controllers	5			
U/R Coordinators		5		
DRG Coordinators		1		
Physicians		4		
Discharge Planners			5	
PRO Administrators				3
Fiscal Intermediary Representatives				6
Nursing Home Administrators			2	
Home Health Agency Administrators			2	
Total Number of Interviews	10	10	9	9

3.0 HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS

3.1 Competitive Environment

The competitive environment in the southwestern Montanta is heavily conditioned by the geography. The hospitals are small and widely scattered and not sufficiently busy to support a full range of specialized services. Given a system of dispersed, spacial monopolies, hospitals are generally observed to be pursuing strategies to reduce leakages of admission flows; that is, expanding in selective specialty service areas so as to stop the referrals of some elective and high tech service cases to major hospital markets in Missoula, Billings, Great Falls, and Helena. To a lesser extent, hospitals in the region are concerned with the leakage of admissions requiring routine services on the perimeter of their service areas.

There remains some competition within the core markets of these hospitals, but not the usual "competition" for resident admitting physicians that one observes within more urban areas. While there is no pressure from HMOs or from corporate entities within any of the markets, there is an obvious spirit of competitiveness between hospitals and local physicians. This pressure stems, in part, from the serious economic development problems in the region and from the limited scope of options available to hospitals for expanding outpatient service revenues, often putting them into competition with physicians who would prefer to provide services in their own offices. One hospital reported that an on-call physician regularly recruited patients from the ER by telling patients "come on over to my office, its too expensive here." Another hospital noted that UR pressure aimed at stopping conduct of minor surgery while patients were under anesthesia for a major (principal) procedure was met with the reaction of not using the outpatient surgical unit for doing the minor surgery at a later date, but recruiting the patients to an outpatient clinic owned by physicians.

Only one instance of direct inter-hospital competition was observed; one hospital was subsidizing two new physicians in a small clinic in a town midway between the two hospitals. The opportunity arose when the physicians' predecessor retired, and the passive hospital apparently did not recognize the opportunity (or the threat) until the other hospital had recruited a physician to fill the practice. The passive hospital, now under new management, is considering construction of an ambulatory care unit (modular construction) on its site.

It seems clear that hospitals do not perceive their viability as dependent strictly on their success in winning 1) the allegiance of admitting physicians; 2) business on the perimeters of their market areas; 3) competitions with local physicians; or 4) competitions with large referral hospitals outside the region. Rather, their survival strategy, as indicated by their actions, seems to rest largely on cost control, complemented by a certain amount of repositioning of the hospital in the varied local and regional markets for patient volume. This approach is probably dictated by the sparse population density, of the region. Most of the repositioning appears to be that of the smaller

hospitals, which have opted to try to capture more of the subacute market, which has been historically somewhat underdeveloped in the region.

3.1.1 Price Competition

There is hardly any indication of historical price competition in the region in any form, nor any indication that the situation is changing. During the last four or five years there were instances in three hospitals of very large price increases motivated by revenue planning failures, capital needs, and softening markets for inpatient admissions. Over the PPS period, price increases have averaged four to six percent for semi-private room rates. The fairly uniform pattern of modest increases of this size throughout the region seems to be dictated more by cost pressures than by market conditions. Hospitals in general have union contracts for much of their labor, which provide two to three percent annual increases. With approximately half of the hospital inpatient business being Medicare, the indicated level of price increase seems about adequate to cover the rate of increase in hospital labor costs. In general, inpatient pricing seems to be driven by a "requirements" philosophy rather than by a market-driven philosophy.

Hospitals seem more aware of market conditions for pricing outpatient services. Emergency room charges in particular have been moderated in one hospital, being cut from thirty two to fifteen dollars per visit. Other hospitals also seem concerned about pricing outpatient services and the competitiveness with physician offices and other hospitals. Prices for such services have reportedly gone up "slower" (than room rates), though no data were made available on rates of increase. The largest hospital in the region is able to pursue a more complex pricing strategy with the establishment of a "center of excellence" in the form of a cancer treatment center, which provides inpatient and outpatient services. As a unique service center in the region, the hospital has been able to moderate price increases for routine inpatient and the usual outpatient service departments and allow prices for the (noncompetitive) cancer center to rise more rapidly.

As indicated above, the indirect form of hospital competition throughout the region has, in general, not caused administrators to pay significant attention to price increases as an element of competitive strategy. While competition for some outpatient services is developing with physicians, there appears not to be too much concern about the level of prices except to provide for the "requirements" of the hospital. On the several occasions where there were very large price increases, apparently for circumstantial reasons, there was no evidence of a significant price elasticity. Why don't administrators rapidly increase prices to guarantee financial survival? It appears that community pressure, particularly about uninsured patients, is an important countervailing concern of boards.

3.1.2 Non-price Competition

Non-price competition is an active concern of hospitals in the region as they attempt to shore up perimeter markets and reposition

themselves in post hospital care services. Four types of non-price competition are discussed:

- post hospital care services
- adoption of other services requiring new physician specialties
- adoption of new services requiring physician recruitment
- advertising and image building

Somewhat of a vacuum exists in the post-hospital care market in this region. Most hospitals are adopting new services with an eye toward providing a more comprehensive package of services over the acute and recuperative phases of illness for persons in the market area they directly serve. Home health care services are poorly organized in the region, with one primary provider on the western edge of the region but with some services being provided by counties as well. Distance is again the principal barrier to the growth of home health care services in this region, making it different from other areas in the country even though availability of these services has increased rapidly in the last five years. The state does have a small case management program for Medicaid and indigent patients. This program provides no services (other than case management), but is used occasionally by hospitals to help cope with qualifying patients who need access to non-skilled services after discharge.

Three hospitals have become certified Medicare providers since the inception of PPS but volumes of care and revenues have not been substantial. In one hospital's market, the local physicians, prefer to treat their homebound patients directly with home visits by the M.D. or office nurses. This somewhat unique attitude among physicians,the geography, and a general lack of enthusiasm about the need for such care among physicians and patients alike have been responsible for the modest revenue opportunities.

Hospitals have also converted subacute beds to swing beds and, in one case, converted acute beds to beds for convalescent care. Since the inception of PPS somewhat over 25% of the acute beds in the area have been converted to lower levels of care. These bed conversions have created an element of competition with the nursing home industry in the state. That industry has recently been responsible for getting legislation enacted which forbids hospitals from keeping patients not requiring acute care in so designated beds (e.g. ANDs) if there is a vacant nursing home bed within a hundred mile radius.

In general, bed conversions have not been a successful strategy on the part of hospitals to generate more revenue from this acute business. Swing beds, in particular, have proven to be a mixed blessing for these hospitals. The revenue source they promised was significant, but never materialized due to widespread perceptions of the administrative burdens posed by the swing bed benefit. Administrative burdens posed by admission forms and patient rights procedures make it simply uneconomical for patient transfer to swing beds when the expected duration of stay is

only several days. Nurses and physicians both find the process sufficiently burdensome that they simply do not convert the patient to swing bed status.

One hospital in the region has converted beds to convalescent care status, which they lease to the private corporation. Another has built a 100 unit retirement living complex. These seem to be the only notable successes of hospitals in the region in moving into the sub acute elderly market in order to achieve significant revenue production. Only one hospital in the region has attempted to convert beds into excluded units (e.g., excluded from PPS). The units (Psych/substance abuse) have proved to be successful as a public relations vehicle but do not seem to have generated significant payoffs in terms of Medicare reimbursement.

Hospitals have sought to expand service offerings in other areas as sources of revenue and public relations devices. One hospital has invested in a significant amount of laboratory equipment following a cost analysis showing that they could be more competitive with both reference laboratories and physician offices. While there has been a marked increase in the use of other outpatient services due to changing practice patterns and PRO intervention, there does not seem to have been sizeable investments that might facilitate the substitution; hospitals appear to be making do with existing facilities and equipment.

Hospitals are providing other services in order to enhance their image within the community. These include well-baby clinics, community health education activities, mammography clinics, blood pressure clinics, etc. These kinds of services and the publicity they generate are especially important to smaller hospitals, which are struggling to maintain an image as a "real" hospital in spite of the fact that they no longer provide many traditional hospital services (many types of surgery and OBG). Administrators in small hospitals perceive these services as a way of stemming the erosion of patients to the larger cities.

The community service activities noted above are complemented in many hospitals by advertising activities. Hospitals in the region feel it necessary to maintain an image consistent with a "real" hospital. This is particularly important for hospitals with an average daily census in the 3-8 range. Hospital visibility in the public media is actively sought and in some cases actually paid for. T.V., radio, and print media are all used by one or more of the hospitals. The advertising is not aggressive, however, in terms of its competitive intent with respect to price or quality. It is generally oriented around an image building strategy which every administrator, save one, perceives as vital to the viability to institution. It was, in fact, surprising how much energy and resources were devoted to public relations and marketing in a region without HMOs and without geographic proximity to other hospitals.

Two of the hospitals have invested resources in community health surveys. This was perceived as a proactive attempt to discover more about their image problems and identify the kinds of services that would be valued by residents in the community. The results of the surveys have been taken seriously and have led to attempts to establish cancer treatment centers, health education programs and well baby programs in the communities.

The most important aspects of service diversification in the region are activities involving physician recruitment. All hospitals were actively implementing important service diversifications of this type. In some hospitals, ophthalmological services are an important target. The region is largely understaffed with ophthalmologists, to the point that appointment queues are 2-3 months long. A proximate city (Missoula) has seen the hospitals become much more aggressive in utilizing the relative surplus of physicians in that area. Hospitals there have recently opened an ophthalmologic clinic which is able to service patients without appointments and has been drawing business out of the study region by offering convenience. Virtually all hospitals are recruiting suitable specialists to stem leakages of this sort.

Two of the hospitals are diversifying in the area of cancer treatment with appropriate physician recruitment. Others are attempting to recruit specialists in the area of ENT, cardiology, neurosurgery, plastic surgery, othopedics, and podiatry. The method of recruiting physicians varies across hospitals. Hospitals in larger areas are attempting to recruit physicians from outside the region.

While intent on the need to augment the physicians supply, it is not common for hospitals to provide income guarantees or other perks to physicians who relocate. Many areas of this region have historically been "attractive" to physicians because of lifestyle considerations and recruitment of specialists is perceived in these places as being relatively straightforward while there may be a year of two year process. Other areas of the region are not attractive places to relocate because of the economic development problems. Hospitals in these regions do appear to make space subsidies and income guarantees available in order to recruit physicians.

The problem with recruitment facing smaller hospitals is quite different. Patient panel size does simply not support specialty care for a full time physician. These hospitals, as in other parts of the country, are pursuing physicians who would be available on a part-time basis. In some instances space is made available on the hospital premises to see outpatients. In some cases, the surgeons do scheduled procedures with both the hospital and the physician billing separately. In other cases the hospital pays the physician a fee for services and seeks reimbursement from payors. These various "circuit" arrangements are being actively pursued for specialties such as podiatry, othopedics, ophthalmology, and urology. In some instances it was not clear that there was any direct net revenue gain for hospitals in pursuing such arrangements, yet it is still perceived as an essential activity to reaffirm the hospital as the place which can provide (or make arrangements to get) acute medical care for the local residents.

There have been a couple of attempts at joint ventures between hospitals and physicians to provide new services. These activities have been in the area of nuclear medicine and cancer treatment, which is widely perceived as an enormous market in the region which is "leaking" to major medical centers. This area, and one instance of a laboratory diversification, have been the only areas where physicians have actively participated in joint venturing in the region.

3.2 Management Cost Controls

Hospitals in the region have relied extensively on cost control as a strategy for coping with the survival threats posed by PPS, the PRO, and economic development in the region. The most important action hospitals seem to have taken is to invest in new management. While hospitals in other regions of the country seem to have been concerned with setting up new organizational structures, the hospitals in this region have been more concerned with having better managers. All the hospitals participating in the case study, save one, have new CEOs. In three instances CEOs were brought in from other regions of the country and faced difficult financial and medical staff relation problems. Information systems in these hospitals were poor or non existent and union pressure posed a substantial constraint, in some cases, to the options available for coping with reduced volumes of business. Many of the ideas about service expansions were brought into the region from outside, including many of the advertising and image building activities.

Hospitals in the region have begun to implement a number of serious cost containment efforts. In the hospitals with new CEOs, sizeable investments have been made in information systems. All preexisting systems, to the extent that there was a system, were not able to generate physician DRG profiles, inventory information, or departmental budget monitoring information. Improvements in these areas have been evident. One hospital has cut inventory carrying costs by twenty percent in the first two months that the new CEO was at the hospital.

Probably the most important contribution of the new professional managers has been in the area of cost. Virtually all hospitals have had to make substantial reductions in labor both general and nursing labor costs. Staff cuts have been substantial, ranging from 15 percent to 50 percent at most hospitals in the last two years. On arrival, one CEO found staffing levels to be 8 FTEs per occupied bed, and after layoffs, the hospital is now staffed at a more consistent industry standard (3-4 FTEs per occupied bed). Two hospitals have implemented primary nursing models, which they believe to be more cost effective as well as providing enriched jobs for difficult-to-recruit RNs. Several hospitals require twelve hour nursing shifts and 4 day weeks as an efficiency measure and as a perk to recruit RNs from other regions. One hospital has also created a surgical nursing department as an aid in controlling RN staffing in the operating room. The administration is attempting to regularize RN staffing (and OR scheduling) using a set of full and part-time nurses, rather than having the old "on-call" system for OR nurses.

Nursing wages are a particularly troublesome area of cost control in these hospitals. Because of the long standing mining industry dominance of the region the labor force in hospitals, including nursing, is heavily unionized. Unions have been aggressive in attempting to maintain wages, but administrators seem to have been successful in signing multi-year contracts with very modest escalation clauses (2-3 percent per year).

Two hospitals have been pursuing significant improvements in the area of department level budgeting and budget control. In these institutions, productivity standards have been developed and information systems purchased in order to provide the necessary management control information. One hospital reported that the old approach of budgeting against projected patient days resulted in very serious cost problems in the first year of PPS, due to a drop in admissions which did not get translated into corresponding reductions in departmental budgets. Now departments are budgeted on the basis of projected inpatient days.

One hospital has implemented a morning admission program for surgery. This program contains costs by admitting surgical patients on the morning of surgery but not assigning a bed until a bed is needed following the surgery (sometime in the afternoon). All pre-operation testing is also billed as outpatient care. Another hospital has invested in considerable laboratory equipment as a result of a cost study done in that department. Capital purchases have generally been restricted in spite of the pass through and have tended to be made in support of outpatient services rather than inpatient ones.

Physician Controls

Hospitals are not aggressively pursuing continued stay review, physician profiling, administrative jaw boning, or skimming and dumping strategies. Two hospitals appear to have physician profile information but do not appear to be using that information to control physicians. There certainly is no evidence that physician sanctions have been used, though there is evidence that physicians have retired early due to oversight and documentation hassles. One hospital administrator described a prevailing attitude toward physician practice management as "going on trust;" another suggested that "we know who is losing us money but we are not acting yet." There is evidence that physicians continue to prescribe drugs and surgical appliances without regard to the financial consequences for the hospital. There is also no evidence that the PRO been particularly tough on hospitals or physicians in denying admissions.

Yet, length of stay and admissions have fallen remarkably, and physicians retired early. These events appear to be the result of considerable administrative "apprehension" that existed at the onset of PPS. Administrators were initially concerned that the "game" required management of practice patterns and were apprehensive about the extent to which this "game" could be played in this region. Administrators apparently were quite aggressive in the initial educational meetings with medical staff and it appears that they vastly overstated the likely impact of PPS on the hospital's revenue stream. Portrayals of "doom and gloom" scenarios seemed common because administrators did not understand the implications of the blending (which turned out to be quite favorable in all but one case). Following the intense and somewhat misinformed educational activities of many of the administrators, physicians did change behaviors in spite of the fact that hospitals were not particularly effective in implementing good control systems.

In addition, PRO requirements for information and justification became more substantial, imposing a "hassle factor" on physicians which was a new approach to the way hospitals had typically done business with physicians in the past. A combination of apprehensive anticipation and documentation burden from the PRO and Medicaid appeared to change physician behavior (and retirement patterns) without implementation of invasive control devices by hospitals. The apprehensive attitude is best illustrated by choice of modifiers in the President's letter of the 1986 Annual Report in one hospital: "We witnessed and probably survived the integration of the DRG into the lexicon and fabric of hospital care... In these changing and puzzling times, effective management becomes increasingly important."

3.3 Hospital Performance Under PPS

The revenue position of hospitals in the region has improved somewhat over the first two years of PPS. Hospitals did suffer fairly sharp (9%) reductions in Medicare inpatient reimbursement during the first year of PPS but recovered during the second, (with an increase of about 11 percent in inpatient Medicare reimbursement). In addition, outpatient service revenues are higher on average.

The improvement in Medicare reimbursement seems to have been a product of three factors: a big increase in the CMI in the largest hospital, an increase in pass-through payments in the larger hospitals, and a modest increase in admission rates (probably a result of initial overeaction on the part of admitting physicians during the first year of PPS). In the second year pass through payments were about 6.5 percent of total inpatient Medicare reimbursement and outlier payments were less than 1/10 of one percent.

Hospital profits generally followed the same pattern, although there are some important extenuating circumstances. Among the smaller hospitals in the region one is definitely doing better, with profits continuing to increase; two are suffering from adverse trends (one of these is showing losses in its second year under PPS. Profit performance in the other hospitals is less clear. The largest hospital in the region, which represents about 50 percent of the market, experienced a large drop in profit (and occupancy) in its first PPS year; it recovered to a small positive profit position in the second. Another of the smaller hospitals suffered a sharp drop of profits in the second year, purely the consequence of a move into a new facility and large debt service expenses.

Occupancy and inpatient utilization is definitely down throughout the region. Virtually all the hospitals have experienced 25 - 50 percent reductions in the patient census from the pre-PPS period. Average lengths of stay are generally down as well, though two of the smaller hospitals have not experienced such reductions. Overall, shortened stays account for less than half of the reduction in occupancy. Hospitals in the region have had a particularly difficult time reducing lengths of stay. This may be due to the fact that lengths of stay for Medicare patients have been very low, in the range of 3.5 to 6 days. The

admission declines, which represent more than half of the occupancy reduction, are largely the result of a trend which began before the implementation of PPS, with some hospitals showing peaks in outpatient activity predating implementation of PPS. It is generally true, however, that outpatient activity in the region is higher as most hospitals start to expand outpatient services to offset declines in inpatient volumes.

Several aspects of PPS are perceived as having an impact on the revenue stream of hospitals in the region. All the smaller hospitals in the region have a cost base lower than regional and national averages. One never sought sole community hospital status; one had SCH status for the first year and dropped out; the others have sole community status and are concerned that giving up SCH will foreclose the option to return, should the national rate materially change. The largest hospital in the region maintains both SCH and rural referral center status and has costs that are approximately equal to the national average. With the exception of the large hospital, others in the region have improved the flow of Medicare payments per case as a result of the blend. SCH is basically providing no protection for any of the hospitals. Financial swings that have been experienced by some of the hospitals in the first years of PPS seem related to volumes of admissions, against which SCH or RRC status is no protection.

Hospitals in the region do not benefit from the current PPS outlier policy. During their second years under PPS, only the large hospital submitted claims for outliers. Low lengths of stay combined with a very modest scope of services in the smaller hospitals, does not seem to generate many opportunities for use of the outlier payment policy. In several of the smaller hospitals, it was not clear that the policy was well understood. While there were instances of occasional long stay patients in these hospitals it was often apparent that the PRO would not have approved the need for continued stay, suggesting that the hospital did not pursue additional payment for that reason.

The capital reimbursement policy of Medicare is a particular concern to these hospitals. Several of the hospitals have older facilities and are considering major renovations or equipment purchases to effect competitive ends. They continue to hold off on these major decisions until the capital reimbursement policy is settled. Within the last year, one of the hospitals in the region moved into a new facility which was financed largely through debt. Capital costs for this hospital went from below 5 percent to 15-20 percent of costs, making them extremely vulnerable to any policy change that would use national or regional averages in computing the payment for capital costs.

PRO activities in the region have had substantial adverse impacts on hospital finances through their effect on physician admitting patterns, though hospitals do not consider the PRO to be tough, and denial rates are low. In much of the region, particularly in markets of several isolated rural hospitals, the economy is stagnating and the referral base of hospitals has been dominated by elderly community physicians. These physicians, and the hospitals that depend upon their referrals, have been heavily influenced by PRO and Medicaid regulations governing admission criteria and the corresponding documentation

requirements. There were reports of dramatic cutbacks in admissions from these physicians who were angered and/or beleaguered by the additional justifications required by the PRO (and Blue Cross and Medicaid). The swings in admissions that apparently resulted from these behaviors has put several hospitals in jeopardy. It would be safe to conclude that in the case of two hospitals, higher Medicare payments per case provided by the PPS blend have generated a cushion that has allowed these hospitals to survive the consequences of adverse trends in admission rates.

In both of these very small hospitals there were extended periods of time in the last two years when only one physician was referring patients to the hospital. These physicians were elderly and experienced difficulties coping with PRO oversight. In both hospitals, other community physicians had retired shortly after PRO requirements were implemented. Given the isolated situation of these and most of the other hospitals in the region, the scope of remedial strategies available to hospitals is limited, generally requiring recruitment of new physicians from outside the region.

Finally, it is important to acknowledge the contribution of property tax and philanthropic support for all the hospitals in the region. While not substantial, in some of the smaller hospitals taxpayer support approaches 5 percent of the revenue base. Additionally, there is a countercyclical pattern of philanthropic contributions to the smaller hospitals which, in one instance, amounted to about 15 percent of revenue in one year. Revenue from taxes and philanthropy are an important smoothing factor in the revenue base of hospitals in the region, that help, along with cost control measures, to allow most hospitals to maintain a positive net surplus in most years in the face of declining admissions and some rather severe volume swings.

3.4 Complaints About PPS

The interviewees registered a number of complaints about the PPS system. The most common complaint concerned the PROs practice of demanding a twenty dollar fee to review post hospital admissions or possible admissions to swing bed status. Hospitals are very indignant about this practice. There is also common agreement that the urban-rural adjustment is unfair; Butte, for example, gets the "rural" index while other cities in Montana get the urban rate. Others argue that the salary requirements are possibly higher in rural areas in this region than the more "urban" places.

One hospital complained about the cost burden of ambulance services to conduct diagnostic tests on patients (like CT scans). This hospital spends approximately $1300 for each round trip to the urban center which must be absorbed as part of the DRG payment. They incur approximately 15-20 trips per year in a hospital having an average daily census of about 8.

Hospitals with swing beds have advocated a simplification of the administrative requirements for such admissions to allow them to make better use of the benefit. Hospital respondents also believe that dropping the ROA (bluesheet) was a big mistake, imposing payment risks

and information gathering burdens on hospitals that were unfair and not accommodated by the PPS rates. Interestingly, hospitals were not enamored of state association proposals to convert the SCH status institutions to cost-based reimbursement. They much prefer PPS as a way of doing business to cost base reimbursement and perceive significant financial advantages from the blended rates.

4.0 PPS AND ALTERNATIVE HEALTH PLANS

There is no reported activity in southwestern Montana with respect to alternative health plans such as health maintenance or preferred provider organizations. Consequently no interviews concentrated on this area.

5.0 MEDICAL PRACTICE PATTERNS UNDER PPS

5.1 Background

The historical practice pattern in this region seems to be typical of large, sparsely populated rural areas. Almost all physicians maintain admitting relationships with a single hospital. Most of the specialty care is referred to hospitals outside the region. The length of stay is quite low, generally below six days average length of stay for Medicare beneficiaries in the pre-PPS period. The low length of stay is a product of both the referral leakages (difficult cases) and because of a conservative style of practice generally.

The response of hospitals to PPS in terms of their interest in controlling physician practices has been conditioned by both the conservative baseline situtation of medical practice in the region and by economic conditions facing most of the hospitals. The isolated hospitals in the region have an average daily census of between 2 and 8 patients and most hospitals are separated by a driving time of more than 1 hour. Two of the hospitals have had only one admitting physician for some time. Consequently, the risks of lost volumes, associated with pursuit of an aggressive patient management strategy in response to PPS are very dangerous for these hospitals. Even the larger hospitals have been faced with situations that would make it difficult, if not financially dangerous, to aggressively pursue changes in physician practice styles.

The most pressing threat to most hospitals' survival is developing and maintaining a stable identity as the acute care center in their market area in the face of the hospitals' small size and inability to provide all specialty services. The smaller hospitals perceive an explicit need to stem the flow of referral leakages to hospitals in other regions. One of the larger institutions also faces severe shrinkage of its catchment area population and hospital volume and is struggling with the prospect of having to contract without threatening its credibility as a viable acute care center. Another of the larger institutions has a severe conflict with a bloc of local physicians. As its administration struggles to reestablish relations with these physicians, it must be particularly cautious of overly aggressive patient management tactics in response to PPS.

Overall, there have been sizeable reductions in admission rates throughout the region due mainly to the application of PRO and Medicaid admitting criteria. Also, there have been reductions in lengths of stay. However, these reductions have apparently not been the result of aggressive continuing stay review but rather were the result of significant apprehensive behaviors of admitting staff, early retirements of older physicians, and an increasing reliance on referrals of difficult cases to specialists and other hospitals.

Length of stay for Medicare cases is down to 3.5-4 days in several of the smaller institutions, but seems to have leveled off (and possibly increased slightly) in the second year of PPS as hospitals began to succeed in stemming some out-referrals. Physicians have begun to recover from their initial apprehension to PPS and have sought to reassert

quality objectives regarding needs for continued stay. The fairly modest, and in some cases totally absent, physician review functions in hospitals have not continued to exert the substantial pressure on physicians which would seem to have been required in order to continue to reduce length of stay.

In no cases were there any observed programs or policies to control the physician's use of ancillary and special care services in hospitals. Nor were there any observed concerted attempts on the part of the hospitals to specialize in favor of profitable cases (or specialize against unprofitable ones). On balance, there appears to have been a one time reduction in admissions and lengths of stay created by the imposition of admitting criteria in conjunction with an apprehensive reaction to PPS implementation.

5.2 Hospital Controls on Practice Patterns

Admissions are down in all hospitals. The reduction is reported to be largely the result of tougher PRO criteria and the elimination of social admissions, which had been fairly routine in all hospitals. There has also been an increase in the rate of outpatient surgery. More prudent admitting in the region has also been due to activities of other payors (Medicaid and Blue Cross), who implemented tough pre-admission certification (PAC) programs in the early 1980's. There is very widespread concern among physicians about admitting criteria because of the universal concern of all payors. Hospitals are fairly passive participants in these processes, ensuring that all candidate admissions are reviewed against applicable criteria. No hospital in the region appears to be doing anything novel to control the admitting practices other than complying with third party payor rules.

While there have been apparent reductions in unnecessary Medicare admissions as a result of PRO criteria, hospital staff and physicians agree that the PRO has not been particularly aggressive about denying payments. All observers agreed that the Medicaid PAC program was very tough and posed a more binding constraint on practice patterns than did the PRO admitting criteria. In addition to affecting the admission rate, the Medicaid PAC has apparently been successful in reducing the length of stay, in as much as no pre-op days are being paid by Medicaid.*

Implementation of admitting criteria and the threat of payment denials by the most important payors has had a substantial impact on physicians. The hassle associated with these programs and the corresponding documentation and justification requirements have been a stark change for physicians in the area, particularly the elderly ones who have been practicing for many years. Frequent stories were told about early retirements and changed admitting patterns. One elderly physician was reported to have become so beleaguered and angered with the regulatory oversight that he failed to admit any patients at all over a three month period!

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*The perception that the Medicaid PAC standards are more stringent than those used by Medicare is a curiosity since the PRO administers both reviews using identical criteria. The difference in the perceived rigor may be due to the fact that the Medicaid program was instituted earlier and in a period when there was less concern in general about utilization review and cost control. By the time Medicare adopted identical standards, providers were accustomed to restrictions. Moreover, Medicaid pays on a per diem basis so that the same criteria applied to two different payment systems will be binding in very different ways.

Intensity Control

Monitoring of stays is done at some level in all hospitals, though two of the smallest hospitals do not have any formal practices in this regard. Only two hospitals prepare monthly profiles of patients by physician. Three hospitals were using face sheets on the chart indicating target length of stays, though one of these hospitals has stopped this practice altogether. Among the new administrators who have assumed management duties in the region recently, there is a clear consensus that the continuing stay review process is much less rigorous than in other regions of the country. Both of the larger hospitals indicated that there are considerable variations across the staff in terms of their adherence to length of stay norms. The aberrant physicians are clearly identifiable, but no actions against them have been taken by the hospitals as of this time. There is no evidence that physicians have been sanctioned for abusive length of stay practices. Still, there is no question that the hospitals are investing more energy in such monitoring than they did in the past.

One observation made in two hospitals was that length of stay practices were sensitive to the presence of daily review. In these instances, the utilization review function was performed by a single nurse and lengths of stay have been observed to be higher when that nurse was on vacation.

Two other LOS control tactics were observed in the region. One of the hospitals had a morning admission program for surgical cases that was designed to control length of stay by reducing pre-operative time in the hospital. In this program, surgical patients report to the hospital on the morning of surgery and are not assigned to a bed until they have left the surgical recovery area. Another length of stay control strategy seen throughout the area is the use of swing beds. As noted earlier, however, these beds are available in every hospital, but they are perceived to be seriously under-utilized because of the high administrative burdens on nurses and physicians of transferring a patient into these beds.

While several hospitals have implemented programs designed to reduce the cost of ancillary services, there is no indication that any institution in the region has attempted to control physician decision making with regard to the use of ancillary or special care units.

Changes in discharge planning activities are probably not an important source of the length-of-stay reduction. Discharge planning activity is informal in these hospitals and generally combined with utilization review and quality assurance activities. (In the smaller hospitals, the head nurse performs all of these duties as well as supervising staff nurses). In one of the larger hospitals discharge planning and social service staff were not permitted to interview patients without written MD orders in the pre-PPS period. Now, the staff are allowed to meet with patients if the patient meets certain high risk criteria. Processes are less formal in the other hospitals and the availability of community support programs is less well developed than in many other regions in the country. This makes the discharge planning process a less proactive one for controlling length of stay than would be observed in many other regions.

Specialization

While hospitals in the region are uniformally aggressive in their pursuit of additional admissions of particular types, there is no indication that the types of patients being recruited have been selected on the basis of the financial gains and losses associated with particular DRGs. Three of the hospitals had attempted studies of physician and patient profiles that would indicate the profitability of particular patient types. These data, which are only informally and intermittantly shared with admitting staff, have provided a basis for impressions, however informal and inaccurate, about the types of cases that are "winners" and "losers." Interestingly, the surgical specialists generally perceive that medical admissions are losers (such as COPD and pneumonia). Medical specialists suggest that surgical cases such as joint replacement are losers. Only one hospital has attempted to conduct financial analyses of DRGs on the basis of costs (as opposed to charges). Costs in this case were approximated by using ratios of costs to charges. Even here, as elsewhere in the region, the results were viewed as more of a curiosity than as a guide to policy.

Most hospital administrators perceive the need to recover patient types they believe are being referred to other hospitals. Considerations of the types of physician specialties that are needed in order to recapture these streams of revenue are being made without any consideration of the per case profitability of the patient types in question. There are no allegations anywhere in the region of "skimming" and "dumping." Volumes of transfer cases appear to be no higher and, if anything, may be somewhat lower in the presence of PPS, as hospitals attempt to cling to patients to maintain their credibility as viable institutions. One hospital provided evidence of severe economic hardship entailed in pursuing this strategy as it related to CT scans for patients. Here, the hospital is willing to incur substantial ambulance charges (absorbed by the DRG payment) to get patients tested in a facility in another city in order to keep the patients from being transferred at the point at which the test is indicated.

Coding Changes

Two of the hospitals in the region appear to use groupers and pay some attention to DRG coding. In one of these hospitals, casemix is up by about 12% in the last two years and physicians here appear aware that upcoding for the discretionary cases is happening and have been convinced that this practice is essential for financial survival under the DRG system. The other hospitals in the region do not seem to devote any resources to reimbursement optimization. The average casemix index is down in two of these hospitals and basically unchanged in the others. In these hospitals, physicians have not been encouraged nor provided with educational material on upcoding.

5.3 Perceived Problems With Respect to Patterns and PPS

Several types of quality problems are identified by respondents in this region. Most of these problems are also mentioned by respondents in other regions of the country. First, there is the issue (mentioned by discharge planners) of the "spontaneous" discharge. Under PPS, physicians are perceived to be more likely to decide suddenly, without notice that a patient is ready to be discharged. This practice poses difficulties for discharge planning staff arranging for whatever aftercare arrangements are indicated.

A second problem noted here more frequently than in other regions, could be characterized as the "apprehensive" non admit. There is evidence in this site that certain physicians, particularly elderly ones, became apprehensive about the degree of hassle and regulatory oversight of admitting criteria and responded to this pressure by slowing the flow of admissions. While this was precisely the regulatory intent, there are indications here that certain physicians may have overreacted initially. There are no indications that serious adverse outcomes resulted from these practices, however.

Several concerns were expressed about the adequacy of the post-hospital care services available in the region. First, the supply of home care services, while growing, is widely perceived as less than adequate, largely because of the enormous geographic distances involved. Secondly, several discharge planning staff commented on the inadequacy of community mental health service providers in all rural areas of the region. Finally, while the supply of SNF and ICF beds in the region seems adequate, there were concerns about the safety of discharging sicker patients to these facilities because of perceived low skill levels of the nursing home staff.

Some physicians express concern about the high and increasing rates of elective surgery done on an outpatient basis. The allegation is that some procedures (particularly hernias) are being done at excessive rates on an outpatient or day surgery basis, where they are free from oversight by the PRO.

There are two concerns about quality of outcomes under PPS that are universally expressed by physicians. Both could be somewhat unique to this area in view of the approach hospitals have taken to respond to PPS here. The first is a concern about the adequacy of nurse staffing in the hospital. As indicated earlier in this report, hospitals have looked to staff reductions, including nursing staff, as a key feature of their response to declining census and PPS incentives. Nursing coverage in the hospital has been dramatically reduced in several of the institutions, decreasing the nursing time available per patient and also tending to increase nurse turnover rates. Physicians talk openly about the increasingly difficult choices that have to be made between extending special care unit stays (ICU, CCU) versus risk to the patient of a return to a routine care unit. Instances are cited of new RNs being given too much responsibility and without being monitored closely enough. As one physician expresses it: the choice facing physicians is to "put the elderly Medicare patient in the ICU or put them on the floor and wonder

what kind of care they are going to get." This same physician observes that the "RNs are finding it harder and harder to do what they need to do and to do what they used to do," creating poor morale and turnover.

A related problem concerns the quality implications of shifting services to the outpatient setting. Concerns are raised about the kind of "staged" treatment that is encouraged by PPS as hospitals attempt to do diagnostic services on an outpatient basis, with a subsequent admission, if needed. Biopsies are offered as an example of a place where quality could be suffering. Doing biopsies under local anesthetic in the outpatient setting (rather than under general anesthesia), makes it more difficult to isolate and remove small lumps. Basically, it is more difficult to do effective invasive diagnostics well, in the outpatient setting. While there are no allegations of general and widespread problems of this sort, there are concerns about potential quality problems.

Finally, physicians complain of the difficult choices about discharge timing, particularly for surgical patients. Due to mining employment, very large numbers of persons in the region have chronic respiratory problems or are prone to pneumonia complications. The concern about respiratory complications of early discharge stems from inadequate post-surgical home care for patients. Patients who have been discharged will often attempt to avoid such activities because of the pain involved, risking fluid accumulation in the lungs and development of pneumonia. Physicians would prefer to keep the patient in the hospital where nurses can force ambulation and coughing to limit the development of respiratory complications. There are seldom suggestions that readmission rates are higher as a result of short stays, but there is concern about the difficulty of the physician's discharge decision, in which patient risks and hospital finances are in direct conflict. However, most physicians in the region (particularly surgeons) believe that PPS incentives have been generally favorable and sensible influences on patient management. It is agreed that too many patients were being admitted, and extended stays occurred too often. Most physicians seem to believe that these practices were due to "bad physicians using hospitals as a place to dump patients they didn't want to deal with in their offices." Hence, they argue that practice patterns have, in part, been improved as PRO/PPS pressures have disciplined such behavior.

6.0 THE POST HOSPITAL HEALTHCARE INDUSTRY UNDER PPS

Southwestern Montana appears to have an adequate quantity of both SNF and HHA care to satisfy hospital aftercare needs. There even appears to be some competition developing in the HHA market as hospitals in the Butte area begin the vertical integration process that is prevalent elsewhere. Discharge planning is informal, with little pressure for a more complicated process. Since hospital occupancy rates (and corresponding discharge rates) are low and post-hospital care placements relatively easy, the post hospital care system seems to operate to everyone's satisfaction with a very loose structure. Reported deficiencies relate to HHA coverage of remote places, a shortage of suitable community mental health providers, and a shortage of community support programs for non medical services.

6.1 Hospital Discharge Planning

Discharge planning in area hospitals is an informal process, most likely because of the low level of staffing in hospitals and the low need for coordination. No hospital in the area has a staff person conducting only discharge planning. Most combine utilization review and discharge planning. Area HHAs and SNFs actively participate in discharge planning to varying degrees.

Many of the area nursing homes report that they are in daily contact with the hospital social services or other staff involved in discharge planning. HHAs have more informal contacts, usually accepting calls from hospital social workers and receiving discharge summaries. Most home health contacts seem to come from physician referrals. While the nursing homes appear to be satisfied with this process, the home health agencies would like more active involvement. One HHA director states that discharge planning should have been legislated for all providers at the time PPS was instituted. The director of the HHA now facing the most new competition is frustrated at not being able to interview patients without a physician order.

Area hospitals prefer to discharge patients to area nursing homes rather than use their own empty swing beds. In one case, this probably is because the hospital had created a longterm care facility from an unused wing. In other cases, there is reference to a "gentlemen's agreement" with local nursing homes. The cost of such an agreement may not have been high, because hospitals' uncertainty about reimbursement for swing beds lowered their utility considerably.

6.2 Home Health Agencies

Area home health services have been provided historically by public agencies, and continue to be so. There is no tradition of visiting nurse associations in Montana, and no proprietary agencies have been established. However, there has been a significant expansion in home health services in Southwestern Montana in recent years, with some evidence of real competition from hospital based providers. One small

hospital, originally served by the HHA of an Area Agency on Aging (AAA), started its own HHA in 1984. A second hospital served by the AAA has recently received CON certification to start its own HHAs. A third small outlying hospital in the region has also reieved permission to start an agency.

The two major HHAs in the area report that Medicare patients comprise about 85 percent of their patient load. Many of these patients have received hospital care in secondary and tertiary care facilities some distance away and have returned home to recuperate. This includes hospitals in Butte, Missoula, and Billings. Both agencies report very few referrals from the very small rural hospitals in the Southwestern area of the state.

Agencies report an increase in both patient load and severity of illness. High tech home health care is available to most patients, and the HHAs contract with a separate supplier for most of these services. One pharmacist contracts with both of the largest HHAs for the initial setup of various high tech forms of care, and the HHA staff then maintains the patient. One agency has a home dialysis patient. There seems to be more convalescence at home than before PPS. One agency director notes that there are also more cancer patients than before, and more receiving oxygen at home.

Most agencies attribute this increase in severely ill patients to the effects of PPS. One agency increased its staff a small amount, but the more common reaction has been to increase hours of operation. Two agencies have gone to seven day a week operation to deal with the "immediacy of discharge" because of the increased number of visits their patients require. Another agency administrator reports that two or three times in the past year, they had to refer a patient elsewhere because of excessive caseload.

Problems in dealing with the fiscal intermediary for the most part involve very slow payments, often taking two to three months for reimbursement. One HHA wanted to apply for a PIP, but was told it was not possible. On the other hand, the FI appears to be very lenient about denials. One agency said, for example, that the FI would certify coverage of MS patients that the director considered custodial care. Both major agencies are on waiver of liability, one stating that it had no denials before January, 1986. All HHA's report good access and fairly clear definitions of terms, with the possible exception of intermittent care. Interestingly, the FI reports problems with the other two coverage requirements for HHA coverage.

Under the regional consolidations taking place across the country, FI duties are being transferred from Blue Cross of Montana to BC of Iowa. The Iowa Blue Cross has been holding workshops to ease the transition. HHAs have the impression that the new FI has a good informal structure for dealing with claims and that they have good physician reviewers. There is, nevertheless, some apprehension about the transition.

6.3 Nursing Home Facilities

Area nursing homes are not overly abundant, all maintaining fairly high occupancy rates, but they appear to have enough capacity to meet

needs. The number of Medicare certified beds,in fact, has been shrinking until recently. Most facilities report an increase in the severity of illness from recent hospital patients, but also try to avoid providing high tech care, such as intravenous care.

Access to Medicare SNF beds appears to be relatively open. One facility with 9 certified SNF beds has an average census of one to two Medicare patients. One outlying home started with 40 Medicare-certified beds and reduced them to 10, and then to 4, due to lack of patients to support the level of care. That facility eventually dropped its certification altogether because of a problem with qualifying patients for skilled care. This appears to be a general problem with most nursing homes in the area, which seem to be providing a great deal of custodial care.

Most of the Medicare patient load for these facilities comes from procedures such as hip replacements, dialysis, surgical postoperative care, and restorative procedures. SNFs have, for the most part, limited the high tech care provided, so that it is concentrated in one Butte nursing home. This home is the only one in the Butte area that provides intravenous care, for example. One director remarked that there was not enough demand to support provision of such services.

While Medicare patients appear to be more severely ill, than before PPS, length of stay does not appear to be increasing by a great deal. One home said that its Medicare patients usually go home when their Medicare coverage ends because the region is such a low income area and not many patients pay for SNF care out of pocket. This same home pointed out that 80 percent of its patient load is on Medicaid.

Many of the outlying nursing homes have arrangements with local hospitals to take in swing bed patients fairly quickly and to shift patients back and forth with relative ease. Most of their patient load appears to be this sort of patient, rather than local citizens who have received care in a secondary or tertiary care center and then transferred back to the area to recuperate. The number of SNF beds in the area has shown some moderate growth. One hospital reduced its bed size, turning the extra beds into a 12 bed SNF facility, all Medicare certified. Other facilities report small increases in Medicare demand.

7.0 PROGRAM OPERATIONS

7.1 Peer Review Organization

The Montana-Wyoming Foundation for Medical Care, which had served as the Montana PSRO, is currently the Professional Review Organization (PRO) in Montana. It also has a contract to conduct reviews for Wyoming, has bid on the Idaho contract, and has several contracts for private pay review.

Recent Phase II budget cuts, combined with Montana's geography, have posed particular problems for the Montana PRO. Faced with a 22 percent reduction in funds, the PRO has had to conduct more off-site reviews. Nineteen out of ninety hospitals have all reviews done off-site. While these facilities constitute only 10 percent of the records to be reviewed statewide, they are small rural hospitals already facing financial difficulties without the burden the off-site reviews impose. In addition, the PRO cut the number of reviewers and those who remained were offered only part-time work, paid on an incentive (per-reviewed case) basis. All salaries were reduced 17 percent and several employee benefits were eliminated. Efforts to generate additional revenue from the hospitals (by billing for special reviews) were pursued, but the practice was halted by intervention by HCFA.

7.1.1 Super PRO Ratings

The PRO thought it had average disagreement rates (11-14 percent) with the Super PRO and brought its quality assurance differences down to less than 1 percent with follow-up documentation. The PRO's DRG validation error rate was a little high, most likely due to having implementing a new system and to a continued problem with social admissions.

In general, the Montana PRO has had difficulty in designing or expanding meaningful objectives given the lack of cases in the state. Representatives felt that getting four objectives in separate areas was difficult for a rural state PRO and that it was forced to spend months of preparatory work "combing" the data for possibilities. Then, having developed an objective, it had trouble meeting it, again because of the small sample sizes. It would much prefer to have greater flexibility to develop an objective where a problem exists and otherwise just to perform the broader generic screens. For example, it felt that transfer and readmission reviews were a waste of time in Montana, where such activity rarely results in denials. In addition, it thinks its focus should shift to outpatient activity.

7.1.2 Quality Assurance and Record Review

Records for review are selected using computerized screens based on readmissions and transfers, a random 3 percent sample, and outlier samples. In addition, the PRO-specific objectives are integrated into the screens, flagging additional records for review. Nurse coordinators review records and make most of the determinations about the appropriateness of services and medical necessity. Problem cases are referred to a physician advisor to make a determination. All physician adviser decisions are reviewed by the Medical Director of the PRO. If

this decision is appealed, an appropriate specialist is called for a second determination. Despite Montana's relatively small physician "pool," obtaining specialty reviewers has posed no problems, except in the case of psychiatry.

Any case pulled for one type of review is automatically reviewed for all areas. This results in about a third of the cases being reviewed. In addition, because the number of COPD cases,and transfer and readmission rates are high, the overall review rate is slightly higher than the U.S. average (33 percent versus 27 percent). Intensified review of COPD is reportedly responsible for a fifteen percent drop in COPD admissions. Select psychiatric diagnoses are also reviewed 100 percent. Prior to the substantial budget cuts, the PRO used to review all complicated deaths and put an entire hospital on 100 percent review where a problem physician practiced. Now, only the problem physician is 100 percent reviewed.

7.1.3 Denials and Sanctions

The PRO acknowledged a low denial rate (3 percent), which it thought was due to effective pressures imposed by PPS to keep lengths of stay and admissions down. In addition, the PRO thought that a higher denial rate would result in the loss of the cooperation of the physicians and that physicians would always be "understanding" of other physicians decisions.

In the past, the PRO has been frustrated by what it perceives to be a lack of support for sanctions. Previously, the PRO recommended sanctions against two physicians, neither of which was supported at the regional level due reportedly to "political reasons." In general, there are a couple of providers at two or three hospitals who repeatedly represent problems. Targeted educational efforts have not improved these physicians' practice patterns. Some of this activity focuses on older physicians practicing in rural settings, who do not have much peer pressure. However, the majority of the activity centers on physicians practicing in two of the largest cities in the state.

7.1.4 Specific Site Issues

Although no institutions in the case study presented any particular problems, there were some comments about small rural hospitals worth highlighting. Initially, swing beds were used to provide intermediate care, not the skilled care they were intended for. This was not observed at any site hospital. Hospitals now call ahead to the PRO to get verification for a swing bed admission, trying to avoid potential denial that will result in their being placed on 100 percent review.

Although the PRO did not mention this, several providers complained that they had been billed for "informational" telephone calls to the PRO. Other complaining hospitals interpreted this as a kind of "incentive payment" to the PRO to ensure favorable treatment of the case in question. The PRO flatly denies these assertions.

Interestingly, some hospitals do not have their own utilization review personnel and hired PRO reviewers to perform their routine on going reviews. Subsequent to the site visit, this review service has been discontinued because the cases referred required two many resources. Though not mentioned, providing utilization review personnel to the hospital and then reviewing their activities as the PRO must have presented some conflict of interest.

7.2 Fiscal Intermediary

The fiscal intermediary in Montana is Blue Cross of Montana, located in Great Falls. Program operations were discussed with individuals from the following areas: Medicare Management, Reimbursement Supervision, Medicare Audit, Claims Processing, and Utilization Review. This summary is organized into four parts: claims processing, utilization review, relations with providers, and external relations.

7.2.1 Claims Processing

Blue Cross processes only about 220,000 Medicare claims per year. Processing is essentially the same for all types of claims, the main difference being the mechanism by which the claims arrive at BC. All SNF and HHA claims are submitted in hard copy and therefore get dated and sorted in the mailroom, whereas almost half of hospital claims are submitted electronically. Given the relatively low volume of claims, BC decided it no longer made sense for the data processing to be done in-house. All data processing has been done by a vendor in Salt Lake City (EDP) since 1982 and the implementation of the UB82 system.

Although BC has good turnaround time with the data processor in Utah (for example, data is entered daily with reports generated that same evening), there were numerous complaints about the data processing not being on site and the degree of management control over data processing activities. Specifically: problems can take 3-4 days to address, the data processor is not particularly responsive to BC's needs; BC staff feel they have little input into necessary software changes; programmers are unavailable to address BC's problems; and an "over emphasis" on processing costs per claim. In addition, a report BC relies on to settle its accounts with the hospitals is consistently of low priority to the Utah processor.

Despite these problems, Blue Cross manages to pay its claims within fourteen days, on average. However, it has failed to meet the requirement that 95 percent of home health agency claims be paid within 27 days -- only 89 percent of claims are paid in this interval.

Problems with providers have caused claim denials; the most frequent problems, by claim category, have been: inpatient claims with secondary coverage that require additional information; situations where preadmission review has not been done for admissions requiring it; some early problems with the Medicare code editor; outpatient-duplicate claims within a single billing period; and SNF claim forms that are incorrectly filled out by small nursing homes which lack the volume to become experienced with the system.

Over time, the volumes of hospital and SNF claims have remained at fairly constant levels, but both home health and outpatient claims have increased in volume. The increase in home health visits is not seen as being due to PPS (since the expanded number of providers pre-dated PPS implementation) but the increase in OPD claims (up about 15%) approximately coincided with PPS.

7.2.2 Utilization and Medical Review

Utilization review activities recently (10/1/86) switched from manual to computerized edit screens. The reviews are done by licensed practical nurses and one medical technician. When questions arise about denials (either beneficiary-or provider-initiated), or questionable cases, a physician is consulted. Likewise, appeals to determination decisions are directed to the physician consultants. Most questions about particular claims are resolved by phoning the provider.

The following list summarizes the types of denials that have occurred and reasons by type of claim:

* outpatient claims-providers seem to bill for non-covered services, perhaps to gain a denial letter to trigger secondary insurance coverage;

* SNF- about 4.6 percent of claims are denied, usually due to levels of care determinations. There has been some nursing home fraud, with homes billing for services that were not provided;

* HHA - all HHA claims are reviewed. Medical denials account for 40 percent of denials, the majority of these (60%) due to the "homebound" requirement.

These problems are fairly consistent across all providers, with certain providers having specific recurring problems.

It is generally perceived that patients are being discharged earlier and sicker, but that most of this is appropriate. Admissions have been denied at certain nursing homes where the patient's needs were too intensive. Some hospitals have called the FI about coverage of high tech or skilled care not normally provided in the nursing home. They are looking for additional payments to the home as inducement to take the difficult-to-place patients.

The FI also notes that nursing homes are providing more rehabilitation services, with increased discharging of patients to the home. Similarly, patients are discharged from the hospital requiring more sophisticated services including hyperalimentation, ventilators, and respirators. Often, the key to successful services delivery is the correct training of family members. Denial problems with home care are mainly due to the "homebound" and "skilled care" coverage requirements.

7.2.3 Relations with Hospitals

The FI provides information to all hospitals regarding DRG-specific payment and outliers, as well as pass-through payments. Providers routinely complain about the inadequacy of outlier payments and the inaccuracy of the capital passthroughs. As a result of more restrictive payment policies, hospitals are aggressively pursuing passthroughs.

Unlike any other FI we visited, BC of Montana has analyzed the hospital industry's experience under Years 1 and 2 of PPS compared with cost-based reimbursement. The experience shows generally improving levels of Medicare inpatient reimbursement over the PPS period in spite of lower admission levels.

7.2.4 Federal Policies and the FI

The FI has scored moderately on the HCFA performance monitoring system (CPEP). Two performance measures have been a problem. First, BC failed the target standard for the proportion of claims processed electronically for the past two years. Second, the data processing costs (when audit and reimbursement costs per claims are considered) are above national averages, in part due to the low volume of claims. In addition, with off-site processing it is felt that they have insufficient control over their processing time per claim.

Hospitals are paid weekly for claims processed using electronic fund transfers to hospitals' banks. Twelve of the larger hospitals use the PIP system. Outpatient claims are paid at 100 percent of charges, with final settlement occurring at year end using a cost-to-charge ratio. Payments using interim cost-to-charge ratios are to begin later this year. The elimination of PIP will affect about ten providers. The remaining two will qualify to stay on. Auditors are glad to see PIP eliminated. In general they say that PIP resulted in over-payments to the hospitals, mostly because of "very poor" budgets. The auditors will no longer need to recover over-payments. Moreover, this will force providers to submit their claims on a more timely basis (under PIP they can take up to a month to submit the claim).

Budget cuts and program changes are a source of real anxiety to Blue Cross. Last year, their budget was changed about 12 times during the year, resulting in considerable uncertainty and budget juggling. In the interim, workers were shifted to the private side of the Blue Cross business and some cross-subsidization occurred between the different lines of business. The budget cuts have led to more accurate cost accounting between the two divisions. These budget cuts, under the old accounting systems, led to a 3-4% loss on Medicare business for the year. The FI will absorb these costs.

All interviewees think the decision to shift to regional processing of home health visit claims is very short-sighted. The providers are dreading the shift. Some are affiliating with hospitals just to avoid it. Both the FI and hospitals will reportedly lose means of communication that resolves problems easily. One FI staffer thinks the beneficiary will lose ultimately, since a long distance phone call is a real disincentive to challenging negative determinations. In addition, FI respondents think that the amount of provider education will decrease, resulting in increased claim denial rates and increased liability for beneficiaries.

The FI basically ignores situations that appear as conflicting directives from HCFA until the issue seems resolved. This included the ordered slow-down of claims processing. They also tend to "shop" for

HCFA answers, first calling the regional office and then Washington, and finally "averaging the answers." They have found the regional office to be inadequately informed about policies and have had to call Washington for answers. In general, the HCFA officials appear to them to be reticent to commit themselves to policy decisions, particularly in putting verbal decisions into writing.

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